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18
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03051

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by the funeral director. Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN 1b 1 Hour	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson	
f. STREET ADDRESS None		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) George		First W.	Middle Bernhardt
4. DATE OF DEATH 3 22 1958		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 4/23/1881	
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Blacksmith	
11. BIRTHPLACE (State or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Andrew J. Burnhardt		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes S.A.W.		16. SOCIAL SECURITY NO. 212-20-7794A 17. INFORMANT Naomi Bernhardt Henderson, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH Sudden Myocarditis Acute Myocarditis Chronic 2043-	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dawson O. George		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Dawson O. George		DATE SIGNED 3/23/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/24/58	
22c. NAME OF CEMETERY OR CREMATORIAL Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire & Greensboro, Md.		24a. REC'D BY REGISTRAR DATE MAR 26 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Albert Leach	

RECEIVED
BUREAU X, S.

MAR 26 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hr. after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3086

CERTIFICATE OF DEATH

03052

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro		c. LENGTH OF STAY IN 1b 80 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Goldsboro		d. STREET ADDRESS None			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None				e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Rose		First	Middle L.	Last Bickling		4. DATE OF DEATH 3	Month 1	Day 19	Year 58
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/17/1877		9. AGE (In years less than birthday) 80 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Isaac Gaesford				14. MOTHER'S MAIDEN NAME No Record					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Charles Bickling		Address Goldsboro, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Arteriosclerotic Cardiovascular Dis. with hypertension						INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Residual Hemiplegia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Residual Hemiplegia							
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Greensboro		20f. (City or town) Greensboro		(County) Maryland	(State) Maryland
21. I certify that I attended the deceased from Jan. 25, 1954, to March 1, 1958, that I last saw the deceased alive on March 1, 1958, and that death occurred at 4:30 P.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Greensboro, Maryland		DATE SIGNED Mar. 3 '58	
ACTUAL SIGNATURE Charles H. Stonesifer, M.D.									
PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/5/58		22c. NAME OF CEMETERY OR CREMATORIUM Greensboro		22d. LOCATION (City, town, or county) Greensboro, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Bocaisi		ADDRESS Greensboro, Md.		24a. REC'D BY REGISTRAR DATE MAR 6 '58		24b. REGISTRAR'S SIGNATURE A. Smith			
VS A15 (4) 15M 9/55									

CEMETECALE DE GEAU

BUREAU X.

MAR 6 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3087

CERTIFICATE OF DEATH

Reg. Dist. No. 03053

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Denton</i>		c. LENGTH OF STAY IN 1b <i>life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		e. STREET ADDRESS <i>Rural Denton</i>	
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Dukes Edward Henning</i>		4. DATE OF DEATH Month <i>MAR</i>	Day Year <i>7 1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Mar. 18, 1895</i>	9. AGE (In years from birthday) yrs. <i>62</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm owner</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>George Henning</i>		14. MOTHER'S M AIDEN NAME <i>Mary</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i></i>	17. INFORMANT <i>Carroll Henning, Denton, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <i>193.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>glaucoma - primary - apparently left brain about 6 mos</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <i></i>			
(c) DUE TO <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. g. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan. 6, 1958</i> to <i>March 7, 1958</i> , that I last saw the deceased alive on <i>March 7, 1958</i> , and that death occurred at <i>7:20 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Paul Thruot</i>		M.D.	
PHYSICIAN'S NAME (Type)		ADDRESS	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Mar 10, 1958</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Denton</i>	22d. LOCATION (City, town, or county) (State) <i>Denton, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. W. Moore, Denton, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 13 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Allesmith</i>

CERTIFICATE OF DEATH

MURRAY V. S.

MAR 13 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3088

CERTIFICATE OF DEATH

Reg. Dist. No.

03054

1. PLACE OF DEATH a. COUNTY CAROLINE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL DENTON		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FLORENCE EVELYN JACKSON		4. DATE OF DEATH Month MAR	Day Year 26 1958
5. SEX F	6. COLOR OR RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 15 1903
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME George Dobson		14. MOTHER'S MAIDEN NAME Ella [Unknown]	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	17. INFORMANT Beverly Jackson Ridge, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CERERAL HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH MAR. 26-58	
33IX Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Hypertension		?	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Mar 25 , 1958, to Mar 26 , 1958, that I last saw the deceased alive on Mar 25 , 1958, and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE H. L. Small		ADDRESS (Street, city or town, state) 507 GAY ST., DENTON, MD	
PHYSICIAN'S NAME (Type) H. L. SMALL, M.D., DENTON, MD		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Mar 29, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Springrove	22d. LOCATION (City, town, or county) Denton, Md
23. FUNERAL DIRECTOR'S SIGNATURE J. Virginie Mooreton Denton		24a. REC'D BY REGISTRAR DATE APR 2 '58	24b. REGISTRAR'S SIGNATURE W. L. Lewis

WISCONSIN STATE GOVERNMENT DOCUMENTATION FILE

REGISTRATION OF DEATH

BUREAU Y. A.

APR 2 1958

REGISTRY

MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

03055

3/89

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton		c. LENGTH OF STAY IN 1b 50 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS Denton	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First: CARRIE Middle: MAY Last: JONES		4. DATE OF DEATH Month: MAR Day: 26 Year: 1958	
5. SEX <input checked="" type="checkbox"/> W	6. COLOR OR RACE WIDOWED <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18, 1879
9. AGE (In years last birthday) yrs. 78	10. IF UNDER 1 YEAR Months: 0 Days: 0	11. IF UNDER 24 HRS. Hours: 0 Min: 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY house	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Ass	
13. FATHER'S NAME John Anthony		14. MOTHER'S MAIDEN NAME Mary Emily Lynn	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Mrs Ruth F. Diggs	
17. INFORMANT Address Denton, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage		INTERVAL BETWEEN ONSET AND DEATH 8 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 28, 1958, to Mar 28, 1958, that I last saw the deceased alive on 3/28, 1958, and that death occurred at 12 noon, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Denton, Md DATE SIGNED 3/28/58			
ACTUAL SIGNATURE DAWSON O. George		PHYSICIAN'S NAME (Type) DAWSON O. George	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar 29, 1958	
22c. NAME OF CEMETERY OR CREMATORIAL Denton		22d. LOCATION (City, town, or county) Denton, Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John W. Monson		ADDRESS Denton, Md	
24a. REC'D BY REGISTRAR DATE APR 2 '58		24b. REGISTRAR'S SIGNATURE D. C. M. D. C. M. D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH — DIVISION OF
CERTIFICATE OF DEATH

BUREAU V.

APR 2 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3090

CERTIFICATE OF DEATH

03056

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely		c. LENGTH OF STAY IN 1b 40 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First EMILY	Middle KIRSCH		
4. DATE OF DEATH Mar. 12 1958	Month Year	Day	Year		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 13 1894		
9. AGE (In years (as of birthday) 63 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland		
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME JOHN BRADBURN			
14. MOTHER'S MAIDEN NAME MARY EDGELL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			
16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the pancreas DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO lying cause (c)		INTERVAL BETWEEN ONSET AND DEATH 14 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, hypertension, atherosclerotic cardiovascular disease		19. WAS AUTOPSY PERFORMED? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18] Blistered			
20c. TIME OF INJURY Hour o. p. p. m.	Month 19	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Queen Anne	(County)	(State)
21. I certify that I attended the deceased from <u>Jan.</u> , 19 <u>57</u> , to <u>March 12 1958</u> , that I last saw the deceased alive on <u>March 8</u> , 19 <u>57</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kurt Lederer M.D. Queen Anne Ad. 3/15 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) KURT LEDERER					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 15, 1958	22c. NAME OF CEMETERY OR CREMATORIAL Holy Cross	22d. LOCATION (City, town, or county) Dear Denton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Moore, Son		ADDRESS Baltimore, Md.	24a. REG'D BY REGISTRAR MAR 21 1958 DATE		24b. REGISTRAR'S SIGNATURE W. B. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or interment, in any event within 72 hours after death.

BUREAU V. S.

MAR 6

PEGGY FE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3791

CERTIFICATE OF DEATH

Reg. Dist. No. 13057

1. PLACE OF DEATH a. COUNTY <u>Caroline</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Denton</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>BURT</u>	Middle <u></u>	Last <u>McKNATT</u>	4. DATE OF DEATH Month <u>MAR.</u> Day <u>8</u> , Year <u>1958</u>		
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 28, 1892</u>		9. AGE (In years, last birthday) <u>65</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.E.A.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Mc Knatt</u>		14. MOTHER'S MAIDEN NAME <u>Georgia Climber</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>WWI</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs BURT Mc KNATT</u>		Address <u>DENTON, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>153.9</u>		DUE TO <u>Cancer of Rectum</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12 months</u>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb.</u> , 1957, to <u>Mar. 8</u> , 1958, that I last saw the deceased alive on <u>Mar. 8</u> , 1958, and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Lawson H. George</u>		M.D.		ADDRESS (Street, city or town, state) <u>Denton, Md.</u>		DATE SIGNED <u>Mar. 8, 1958</u>	
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>MAR. 11, 1958</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>DENTON</u>		22d. LOCATION (City, town, or county) <u>DENTON, MD</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. DENTON</u>		ADDRESS <u>DR. R. DENTON</u>		24a. REC'D BY REGISTRAR DATE <u>Mar. 13, 1958</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. DENTON</u>	

REAU V. L.

MAR 16 1963

REGD. U. S. PAT. & T. OFF.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **03058**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial-cremation, or removal.

1. PLACE OF DEATH a. COUNTY CAROLINE		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLSBORO		c. LENGTH OF STAY IN 1b 7 mos				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ALICE MARI MEADOWS		4. DATE OF DEATH MAR. 7, 1958	Month Day Year			
5. SEX 7	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH AUG 5, 1957	9. AGE (in years last birthday) — yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) MARYLAND			
13. FATHER'S NAME THOMAS MEADOWS		14. MOTHER'S MAIDEN NAME ANNIE BLOCKSTON				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	17. INFORMANT Mrs. Thos. Meadows Hillsboro			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X DUE TO Bilateral Lobular Pneumonia INTERVAL BETWEEN ONSET AND DEATH 24 hr						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Denton	(County) Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>						
ACTUAL SIGNATURE Lawson D. George	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 3/7/58		
EXAMINER'S NAME (Type) Lawson D. George	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Mar 8, 1958	22b. DATE THEREOF Mar 8, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Denton	22d. LOCATION (City, town, or county) (State) Denton, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE George Morrison Denton Md.	ADDRESS 21. X		24a. REC'D BY REGISTRAR DATE MAR 13 '58	24b. REGISTRAR'S SIGNATURE George Morrison		

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3193

CERTIFICATE OF DEATH

Reg. Dist. No.

03059

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hurlock		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First Marie	Middle Nepert	Last Nepert	4. DATE OF DEATH March	Month 6	Day 1958	Year
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-10-1895	9. AGE (In years last birthday) 62 yrs	IF UNDER 1 YEAR Months 2	IF UNDER 24 HRS. Hours 24	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Housewife	11. BIRTHPLACE (State or foreign country) Baltimore, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.
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13. FATHER'S NAME George Fuchs	14. MOTHER'S MAIDEN NAME Elizabeth Hollstein
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	16. SOCIAL SECURITY NO. 215-18-3122	17. INFORMANT John Nepert	Address Hurlock, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 26 minutes
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from 3/14, 1958, to 3/14, 1958, that I last saw the deceased alive on 3/14, 1958, and that death occurred at 7:00 PM, from the causes and on the date stated above.						
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ACTUAL SIGNATURE Harold B. Plummer	M.D.	ADDRESS (Street, city or town, state) Preston Maryland	DATE SIGNED 3/15/58
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/9/58	22c. NAME OF CEMETERY OR CREMATORIAL Jr. O.U.A.M.	22d. LOCATION (City, town, or county) Preston	(State) Md.
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23. FUNERAL DIRECTOR'S SIGNATURE John H. Fuchs	ADDRESS Preston	24a. REC'D BY REGISTRAR DATE MAR 12 '58	24b. REGISTRAR'S SIGNATURE John H. Fuchs
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3994

CERTIFICATE OF DEATH

Reg. Dist. No. 03060

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ridgeley</i>		c. LENGTH OF STAY IN 16 <i>life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Ridgeley</i>		e. STREET ADDRESS <i>Ridgeley</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ALBERT</i>		First <i>ORRELL</i>	Middle <i>SAULSBURY</i>
4. DATE OF DEATH <i>MAR 17</i>		Last <i>1958</i>	Month Day Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAR 27, 1890</i>
9. AGE (In years, last birthday) <i>67 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CANNER-OWNER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>CANNING + FROZEN Foods</i>	
11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>IRWIN T. SAULSBURY</i>		14. MOTHER'S MAIDEN NAME <i>MARY REBECCA ORRELL</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>MRS A. O. SAULSBURY RIDGELEY, MD.</i>	
17. INFORMANT <i>MRS A. O. SAULSBURY RIDGELEY, MD.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>154X</i>		INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>(b)</i>			
DUE TO <i>(c)</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>260X Diabetes mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19 — p. m. — — —		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from <i>April 16, 1958</i> to <i>Mar. 17, 1958</i> , that I last saw the deceased alive on <i>Mar. 16, 1958</i> , and that death occurred at <i>6 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>RIDGELEY, MARYLAND</i>		DATE SIGNED <i>3/22/58</i>	
ACTUAL SIGNATURE <i>C. H. Winnacott</i>		22. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
PHYSICIAN'S NAME (Type) <i>C. H. Winnacott, M.D.</i>		22b. DATE THEREOF <i>Mar. 20, 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Greensboro</i>		22d. LOCATION (City, town, or county) <i>Greensboro, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Virginia Moore Bow, Directors, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>Mar 26, 1958</i>	
		24b. REGISTRAR'S SIGNATURE <i>Dee C. C.</i>	

COMMONWEALTH OF MASSACHUSETTS
CENSUS OF 1950

BUREAU X. L.

MAR 26 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3095

CERTIFICATE OF DEATH

03061

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro		c. LENGTH OF STAY IN 1b 38 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro	
d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Harry	Middle Albert	Last Schnapp
4. DATE OF DEATH	Month 3	Day 14	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/31/1884
9. AGE (In years from birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Penns.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Schnapp		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Henry Spiering		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 433.1 DUE TO Passive Cerebral Lesions Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arterial Embolism (c) DUE TO	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 days 2 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-8, 1958, to 3-14, 1958, that I last saw the deceased alive on 3-14, 1958, and that death occurred at 1 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) ROBERT H. WRIGHT, M.D., Maple Ave., Greensboro, Md.	
ACTUAL SIGNATURE		DATE SIGNED 3-15-58.	
PHYSICIAN'S NAME (Type) ROBERT H. WRIGHT			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/17/58	
22c. NAME OF CEMETERY OR CREMATORIAL Greensboro		22d. LOCATION (City, town, or county) (State) Greensboro, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire, Greensboro, Md.		24a. REC'D BY REGISTRAR DATE MAR 19 '58	
		24b. REGISTRAR'S SIGNATURE Aut. 1958	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the certificate page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED STATE DEPARTMENT OF HAWAII - STATE OF HAWAII

CERTIFICATE OF REGISTRATION

BUREAU Y. S.

MAR 19 1965

RECEIVED